STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155342	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON NURSING AND REHABILITATION CENTER	1415 COUNTRY CLUB ROAD MOUNT VERNON, IN47620

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 17, 18, 19, 20, 21, 23, 2011 Facility number: 000234 Provider number: 155342 AIM number: 100273490 Survey team: Amy Wininger, RN TC Diane Hancock, RN Martha Saull, RN (May 17, 18, 19, 20, 23, 2011) Census bed type: SNF: 7 SNF/NF: 63 Total: 70 Census payor type: Medicare: 12 Medicaid: 45 Other: 13 Total: 70	F0000	The preparation and/or execution of this plan of correction does not constitute agreement or admission by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.We respectfully request a desk review for the plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 15 Supplemental sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5/31/11 by Jennie Bartelt, RN.			

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F0156 SS=E	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure residents were informed orally and in writing of changes in facility rules prior to the change taking place, for 4 of 4 residents affected among 6 residents in a supplemental sample of 6 residents in the group interview. The four resident reported microwaves were removed from their rooms before they were notified of a rule change for use of microwaves ovens. (Residents #105, #102, #103, #104) Findings include: 1. On 5/18/11 at 11:15 A.M. a meeting was held with 6 residents, who were identified by the Administrator to be alert, oriented and reliable for interview. Resident #105 indicated the residents were "not happy with the microwaves." Resident #105 indicated the microwaves the residents had in their rooms "were there in our rooms and a few months ago,	F0156	F156The Center informed the current in-house residents and or the responsible party orally and in writing of the centers rule/policy change on the use of microwaves in resident rooms. Future rule/policy changes and the effective date of change will be reviewed and communicated to the resident and or responsible party orally and in writing by the Administrator or designee. Rule/policy changes are reviewed monthly during Quality Assurance to ensure residents and or responsible party were informed orally and in writing. All new admissions will be made aware of this policy change.Systemic Change by 6/6/2011.	06/06/2011

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	they just came and took them." Resident #102 indicated he "just got a letter today about it." Resident #103 stated, "Kind of cripples us if something comes in cold and we have to go to therapy or Level 2 (other nursing unit) to heat it up." Resident #105 stated, "I think they should check every person and those that can handle it should keep it." During the meeting, Resident #104 also indicated she had a microwave in her room that was taken. 2. On 5/20/11 at 11:50 A.M., the Administrator was interviewed regarding removal of microwaves from individual resident rooms. She indicated the corporation directed the facility to remove all microwaves from resident rooms. This directive was made after an incident in another state where an alert and oriented resident intentionally heated a substance and poured it on another resident. The facility immediately removed all the microwaves and stored them, or asked family members to take personal microwaves. The Administrator indicated she received, from the facility corporation, a written policy and procedure, and a letter to give to the residents and families regarding the new policy that residents would not be allowed to have microwaves in their			

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	rooms. She indicated she received the information "a couple weeks ago." The Administrator indicated she had been out of the building for one week and had just rolled out the new policy and procedure on 5/16/11. The Social Services Employee had talked to the alert and oriented residents and provided them with a letter. The letters to the families were due to be mailed. Two letters were provided by the Administrator, on 5/20/11 at 12:10 P.M., identical letters addressed to the resident and the family member respectively, dated May 16, 2011. The letters indicated the following: "...As you know, the people we serve have a range of medically complex conditions and in some instances, cognitive abilities can be compromised due to medication or other issues associated with these conditions. In the past, we have allowed residents to have personal microwaves in their rooms for convenience. There is a risk of harm if food or beverages are consumed at high temperatures or if they are handled when containers are too hot. This is compounded when people have either physical or cognitive limitations. In order to maintain a safe environment for everyone, we will no longer permit the use of personal microwaves in resident			

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	rooms due to the potential for harm. Microwaves will be accessible for visitors and staff to heat food and beverages to accommodate resident needs and preferences. You may have already noticed this process has been initiated..." The procedure entitled Microwave Heating Food, was provided by the Administrator on 5/20/11 at 12:10 P.M. The procedure was dated as "Effective May 2011." The policy indicated residents had the right to choose to consume foods brought in from outside sources. The facility allows food to be heated in the microwave for the resident, by visitors, staff, or family. The procedure outlines the responsibilities of the facility to provide food and beverages properly and at appropriate temperatures. The procedure indicated the facility would place microwaves in an area accessible to families, staff and visitors, but not accessible to the cognitively impaired. The procedure outlined safety instructions for heating and transporting food, aimed at family, staff and visitors. 3.1-4(a)			

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F0242 SS=E	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review and interview, the facility failed to ensure resident choices were honored for use of microwave ovens and foods served. The deficient practice related to microwave ovens affected 4 of 4 residents in a supplemental sample of 6 in the group interview. The four residents reported microwaves were removed from the rooms of all residents based on a change in facility policy without consideration of their personal needs and desire to maintain their microwaves in their rooms. (Residents #105, #102, #103, and #104) The deficient practice related to food choices affected 3 of 6 residents in the supplemental sample of 6 interviewed during the group interview, and 2 of 13 sampled residents observed during meal service, in that foods residents reported they did not like were served during the	F0242	F242Residents and or reponsible parties were informed of the change in policy/rule regarding microwaves in resident rooms due to cognitive deficit of some Center residents whom are incapable of understanding the use of microwaves or the harm they may cause. Current in-house residents/reponsible party were informed orally and in writing of the policy/rule change of microwaves in the resident rooms due to potential harm to Center residents, families, staff and visitors.The residents have the right to choose to consume foods brought from outside sources. To accomodate resident choice and meet the needs of the residents, the Center has a microwave in an area accessible to families, visitors and staff, but not accessible to cognitively impaired residents. This is to provide a means of heating resident food or drink per choice. Future	06/06/2011

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	meal. (Residents #103, #105, #102, #104, #3, and #57) Finding includes: 1. On 5/18/11 at 11:15 A.M. a meeting was held with 6 residents, who were identified by the Administrator to be alert, oriented and reliable for interview. Resident #105 indicated the residents were "not happy with the microwaves." Resident #105 indicated the microwaves the residents had in their rooms "were there in our rooms and a few months ago, they just came and took them." Resident #102 indicated he "just got a letter today about it." Resident #103 stated "Kind of cripples us if something comes in cold and we have to go to therapy or Level 2 (other nursing unit) to heat it up." Resident #105 stated "I think they should check every person and those that can handle it should keep it." During the meeting, Resident #104 also indicated she had a microwave in her room that was taken. On 5/20/11 at 11:50 A.M., the Administrator was interviewed regarding removal of microwaves from individual resident rooms. She indicated the corporation directed the facility to remove all microwaves from resident rooms. This directive was made after an incident in		policy/rule change will be reviewed by the Administrator/designee to ensure residents have the right to make choices.Policy/rule changes are reviewed during monthly Quality Assurance to ensure residents have the right to make choices.Systemic change by 6/6/2011.Residents #103,105,101,3,57 dislikes have been updated by NSM.Dietary staff have been re-educated on tray cards to ensure dislikes are being followed.NSM to meet monthly with resident council to ensure dietary dislikes are being followed. A list of all resident dislikes is placed in a binder located in the dietary department, as well as on the tray cards to re-enforce resident dislikes. Binder will be available at all times for dietary staff.NSM or designee will observe 2 tray lines 5 times a week for 1 month. Then weekly thereafter.Alert and oriented residents will be interviewed by NSM weekly for 1 month, then monthly thereafter for accurate delivery of food.Interviews will be reviewed weekly by Administrator or designee. All results will be reviewed at monthly Quality Assurance meeting with interdisciplinary team.NSM responsible.System change by 6/6/2011.	

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	another state where an alert and oriented resident intentionally heated a substance and poured it on another resident. The facility immediately removed all the microwaves and stored them, or asked family members to take personal microwaves. 2. During the group interview, on 5/18/11 at 11:15 A.M., 6 residents were present who were identified by the Administrator as alert and oriented and interviewable. Residents #103, #105, and #102 indicated they were served foods they had reported to staff they disliked. 3. During the evening meal, on 5/19/11 at 6:10 P.M., Resident #3 was observed being fed her supper by CNA #3. The supper meal included, but was not limited to, pureed potato salad and baked beans. The resident's paper tray card was on the tray. Review of the tray card at this time, indicated the resident's food dislikes included, but were not limited to, potato salad and baked beans. CNA #3 indicated, "I tried to give her some of each and she wouldn't eat them." 4. Resident #57 was observed with her evening meal, eating in her room, at 6:15 p.m. on 5/19/11. Review of the resident's paper tray card indicated, "Avoid cantaloupe." The fruit bowl she had			

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	included balls of cantaloupe. 3.1-3(u)(3)			
F0363 SS=D	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation and record review, the facility failed to ensure menus were followed, for 1 of 13 sampled residents reviewed for meal service, in the sample 15. (Resident #57) Finding includes: 1. Resident #57 was observed during the	F0363	F 363Resident #57 diet order has been clarified.NSM to observe 2 tray lines 5 times a week for 1 month, then weekly thereafter to ensure proper food is delivered to all residents.Staff have been re-educated on how to follow a tray card for accuracy.Alert and oriented residents will be interviewed weekly for 1 month by the NSM, then monthly thereafter to ensure accuracy of food delivery per tray card.NSM to attend resident council monthly.Interviews will be reviewed by the Administrator or designee weekly.All results will be reviewed at monthly Quality Assurance meeting with interdisciplinary team.Systemic change by 6/6/2011.	06/06/2011

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	evening meal on 5/19/11 at 6:15 p.m. She received mashed potatoes and gravy, a chicken salad sandwich consisting of two slices of bread and a small amount of chicken salad, and a bowl of fruit. Resident #57's clinical record was reviewed on 5/23/11 at 9:45 a.m. The physician's orders, signed by the physician on 5/4/11, indicated the resident was on a CCHO [controlled carbohydrate] NAS [no added salt] diet, with specific orders, "serve extra eggs, meat and cottage cheese daily w/ lunch [with lunch] and supper per dialysis dietician rec. [recommendations]." The resident did not receive extra meat [or chicken salad], or cottage cheese with her supper meal. 3.1-20(i)(4)			
F0364 SS=E	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. A. Based on observation, record review,	F0364	F 364Residents	06/06/2011

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	and interview, the facility failed to ensure food temperatures were maintained at a palatable temperatures for 1 of 1 resident whose breakfast tray was tested and 6 of 6 alert and oriented residents present in the group interview. (Residents #100, #101, #102, #103, #104, #105, #53 , #25) B. Based on observation, interview and record review, the facility failed to ensure a recipe was followed during pureeing of the food, to ensure nutritive value was conserved, for 1 of 1 observation of preparation of pureed food (5/19/11 noon meal), in that menued portion of water was not added to the meat. This deficient practice had the potential to affect 16 residents who received pureed meals. Findings include: A1. On 5/17/11 at 3 P.M., the Resident Council Meeting Minutes were reviewed from the March 2011 meeting. The March 2011 minutes indicated a resident concern with hot foods being cold and cold foods being warm. The DM (dietary manager) assured she would run test trays to check temps (temperatures). On 5/18/11 at 11:15 A.M., the group interview was held. Six [6] residents were present who were identified as alert		100,101,102,103,104,105,53 and 25 food temps have been individually checked by NSM.The order of the dining room carts has been changed to better ensure temperature control of foods.Center has purchased plate warmer covers for stationary dietary plate warmer to ensure accurate food temperatures.NSM will complete test trays 2 times daily, 5 times per week to ensure proper temperatures. These test trays will vary in location to ensure accurate testing and food temperatures.NSM will interview alert and oriented residents to ensure proper temperature of food weekly for 1 month, then monthly thereafter.Results of tray line tests and interviews will be reviewed weekly by the Administrator or designee.Dietary staff have been re-educated on appropriate food temperatures.NSM responsible. All results will be reviewed at monthly Quality Assurance by interdisciplinary team.Systemic change by 6/6/2011.Cook #1 has been counseled and re-educated on proper food preparation and menu instructions.The prepared food on 5/19/2011 was not served out to the residents incorrectly. There were no negative outcomes to the residents receiving puree diets.All cooks have been re-educated on following menu instructions. NSM will observe daily preparation of 1 puree meal for 1 week to ensure	

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	and oriented by the facility Administrator. Resident #100 indicated the following regarding the food "Temperatures not good." Resident #102 indicated "I ate cold eggs ever since I've been here. Breakfast is the worse for cold food." Resident #100 indicated by the time he gets his tray, the ice cream is "mushy." Residents #101, #103, #104 and #105 indicated the food they received on their meal trays was not hot. On 5/19/11 at 7:20 A.M., Resident #53 was observed sitting in the dining room sleeping in her chair at the table. The resident was observed to have her breakfast plate sitting in front of her on the plate, uncovered. At 7:30 A.M., CNA #1 sat down beside the resident and put a clothing protector on her. She then started to feed the resident her breakfast. The temperature of the resident's scrambled eggs was checked with a thermometer and tested 98 degrees Fahrenheit and was read by CNA #1. The scoop of pureed sausage was also tested with a thermometer and read by CNA#1 with a temperature of 104 degrees Fahrenheit. The thermometer was held in each food type at least 30 seconds before being read. On 5/19/11 at 7:33 A.M., the Unit 1 tray cart was observed to be wheeled down to		menu is appropriately followed. In addition each cook will be observed preparing a puree menued item.Results of puree observations will be reviewed by the Administrator.NSM responsible.All results will be reviewed monthly at the Quality Assurance meeting with interdisciplinary team.Systemic change bt 6/6/2011.	

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	155342	A. BUILDING 00 B. WING	05/23/2011

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	the far end of the hall from the nursing station. At 7:45 A.M., RN #1 was asked to get Resident #25 a test tray. At 8 A.M., Resident #25 was served the replacement tray from the kitchen, which was ordered at 7:45 A.M. and when it arrived to the unit, was placed on the tray cart. The original tray had temperatures checked of the following foods and were read by the DON (Director of Nursing): Omelet (was cut in half and stacked) temperature read by DON at 105 degrees Fahrenheit and a sausage patty (also cut in half and stacked) temperature by the DON as 85 degrees Fahrenheit. At this time, the DON was interviewed. She indicated the meal plate of Resident #25 was "barely" warm. At 8:10 A.M., Resident #25 was interviewed. He indicated his breakfast was warmer than usual that morning, but "usually get a cold one." On 5/19/11 at 2:15 P.M., the FSM (Food Service Manager) provided a copy of the policy and procedure for "Test Tray - Quality Validation." This policy was most recently updated July 2010. This policy included, but was not limited to,the following: "...The temperature at point of service should be or (sic) 120 degrees for hot food and..."			

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	On 5/20/11 at 8:50 A.M., the FSM was interviewed. She indicated in response to the March 2011 Resident Council Meeting Minutes, she had monitored food temperatures. At this time, she provided copies of the "Test Tray Audit" she had done. The results were as follows: On March 8 and 9 the breakfast meal had test trays audited. For both audits, which included scrambled eggs on 3/9/11, the results included: Hot breakfast item was 186 F (Fahrenheit) or over on the line and at point of service the temperature was 148 F or above. The Milk for these meals had a temperature of 36 degrees or below on the tray line and at point of service was 38 degrees F or below. On 3/11/11 the supper meal was audited. The hot foods on the tray line tested at 186 degrees F or above and the cold food tested, which included ice cream on the tray line, at 30 degrees or below. The milk for this meal tested at 34 degrees F on the tray line. At point of service, the hot food tested at 142 degrees F or above and the ice cream tested at 31 degrees and the milk tested at 36 degrees. B1. On 5/19/11 at 11:10 A.M., Cook #1 was observed preparing the noon meal. She was interviewed at this time. She indicated there were 16 residents who received pureed meats but she was preparing 20 servings to make a little			

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	extra. She was observed to put chicken cubes in the food grinder, and then she took a small bowl with a yellow paste type material in it. The amount of yellow paste type material was under 1/2 cup in total amount and appeared to be of a consistency thicker than pudding. A recipe book was observed on the counter. Review of this recipe indicated the following: "Soup base, chicken, for 5 servings 1 TBSP (tablespoon); Water 2 cups, Food Thickener...1 TBSP." Instructions included: "Combine soup base, water and thickener to make a slurry. Process chicken meat with slurry until smooth and of desired consistency...." On 5/19/11 at 11:25 A.M., Cook #1 was interviewed. She indicated she had read the recipe incorrectly. Cook #1 indicated for 20 servings of pureed chicken, she should have added a total of 8 cups of water to the soup base and food thickener, but instead she only added 4 tablespoons of water. When Cook #1 was made aware of the amount of recipe water (8 cups) to be added for 20 servings, she stated, "I looked at the recipe wrong. That's why it is so thick." On 5/20/11 at 11 A.M., the FSM (Food Service Manager) provided a copy of the recipe as observed on 5/19/11 during the			

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	food preparation. This recipe indicated for 20 servings of the pureed chicken, there should have been a total of 8 cups of water added to the food for the pureed chicken preparation. 3.1-21(a)(1) 3.1-21(a)(2)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure nursing staff washed and/or sanitized hands between resident contact, in that 1 of 5 nurses observed during medication	F0441	F441Residents #40,43,46,51,50,32,33,36 and 7 had no negative outcome.To ensure proper handwashing is being followed at all times, nursing staff have been	06/06/2011

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	pass failed to wash her hands between resident contact (LPN #1). This occurred for 9 of 25 residents observed during medication passes. (Residents #40, #43, #46, #51, #31, #50, #32 #33, #36) One (1) of 5 CNAs observed providing resident care failed to wash and/or sanitize her hands between resident contact. (CNA #2) This affected 1 of 6 sampled residents observed receiving personal care, in the sample of 15. (Resident #7) Findings include: 1. A. During the medication pass observation on 05/19/11 at 1:30 P.M. LPN [Licensed Practical Nurse] #1 was observed exiting a resident's room with a bottle of eye drops. LPN #1 was observed to put the eye drops into the medication cart and remove her gloves. LPN #1 indicated at that time that she had just finished administering the eye drops to a resident. LPN #1 was observed to not wash her hands or apply anti-microbial gel before preparing preparing the medication for Resident #40. LPN #1 was then observed to administer the medication to Resident #40 and was observed to return to the medication cart.		re-educated on proper hand washing techniques.Hand washing audits will be completed daily by nursing administration or designee every shift for 7 days, then daily for 30 days.A hand washing education had also been initiated prior to annual survey ending. This will continue to occur quarterly with all staff and with new hires.DON/designee responsible and will monitor audits.Adminstrator to review audits daily.All results will be reviewed monthly during Quality Assurance by interdisciplinary team.Systemic change by 6/6/2011.	

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	LPN #1 was observed not washing her hands or using anti-microbial gel. LPN #1 was then observed to prepare medications for Resident #43. LPN #1 was then observed to administer the medication to Resident #43, remove her gloves, and apply anti-microbial gel to her hands, In an interview at that time, LPN #1 indicated, "My hands are raw from washing them so many times." LPN #1 was then observed to prepare and administer medication to Resident #46. LPN #1 was observed to not wash her hands or use anti-microbial gel. LPN #1 was then observed to prepare and administer medication to Resident #51. LPN #1 was observed to not wash her hands or use anti-microbial gel. LPN #1 was then observed to prepare and administer medication to Resident #31. LPN #1 was observed to not wash her hands or use anti-microbial gel. In an interview with LPN #1 on 05/20/11 at 11:50 A.M. she indicated, "I'm a germaphobe, scared of germs." 1. B. During the medication pass on 05/20/11 at 11:52 A.M., LPN #1 was observed to prepare and administer			

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	medications to Resident #31. LPN #1 was then observed to not wash her hands or use anti-microbial gel. LPN #1 was then observed to prepare and administer medications to Resident #50. LPN #1 was then observed to not wash her hands or use anti-microbial gel. On 05/20/11 at 12:05 P.M. LPN #1 was observed to prepare and administer medications to Resident #33. LPN #1 was then observed to not wash her hands or use anti-microbial gel. LPN #1 was then observed to prepare and administer medications to Resident #32. LPN #1 was then observed to not wash her hands or use anti-microbial gel. LPN#1 was then observed to prepare and administer medications to Resident #36. LPN #1 was then observed to not wash her hands or use anti-microbial gel. In an interview with LPN #1 on 05/20/11 at 12:230 P.M. she indicated, "I wash my hands when I can, I am supposed to use gel or wash often." The Policy and Procedure for " Hand Hygiene-plain soap and water handwash" provided by the DoN [Director of Nursing] on 05/23/11 at 10:30 A.M. indicated, "Hand hygiene is the most			

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	important procedure for preventing Healthcare Associated Infections...A plain soap and water handwash may also be used: ...before having direct contact with residents...after removing gloves." The Policy and Procedure for "Hand Hygiene-Alcohol Based Hand Rub: ...An alcohol based hand rub may be used:...before having direct contact with resident...after removing gloves." 2. On 5/18/11 at 2:35 p.m., CNA #2 was observed to be finishing up changing Resident #7's incontinence brief. She was wearing gloves, finished placing the clean brief on the resident, repositioned the resident, removed her gloves, and proceeded to Resident #14's room. She then put on a clean pair of gloves and was preparing to assist Resident #14 to the bathroom. No handwashing was completed between residents. She was questioned regarding handwashing, after she had placed the new gloves on her hands. She indicated, "No, I didn't wash them, but I will now." 3.1-18(l)			